pyramidal tracts is to be ascribed directly to variations in the pyramidal decussation.2 In 1898 Marie and Guillain described two types of degeneration of the direct pyramidal tract, a *type cerebrale* and a *type mesencephalique,* the one depending on a lesion in the cortex or subcortex, the other due to a lesion in the mid-brain. In that of cortical origin the degeneration of the direct pyramidal tract was small and insignificant, while the degeneration of the direct pyramidal tract of mesencephalic origin was larger, of a crescent shape, and could be traced through the dorsal region of the cord. The Dejerines show quite clearly by numerous cases and illustrations the fallacy of this view, and that the degeneration of the direct pyramidal tract of the so-called *type cerebrale* and *type mesencephalique* is due to nothing more than to natural variations in the pyramidal decussations.

J. RAMSAY HUNT (New York).

MISCELLANY

A NEW ANALGESIC TRIGEMIN. Overlach (Berl. Klin. Woch. Vol. 40, No. 35).

This new remedy is a chemical derivative from pyramidon, produced by the action of butylchlorhydrate on the latter. Clinical tests with this drug have lately been made by Overlach, which seem to demonstrate that it has a specification on the painful affections of the cranial nerves. It does not produce any gastric irritation, and has no eeffct on the heart, as the two constituents neutralize each other. It can therefore be employed in organic heart disease. Favorable effects were observed in headaches from exertion, in those from influenza, alcohol, migraine, etc. It is also of particular value in occipital neuralgia and facial neuralgia, both in extensive and localized types, and in toothache. The adult dose is from 0.5 to 1.2 grams; a moderate dose once or twice daily is usually sufficient.

JELLIFFE.

ATROPHY OF HAND MUSCLES. D. I. Wolfstein (Jour. Amer. Ass'n, April 9, 1904.)

The writer reports a case of a woman, age 27, showing (*a*) isolated atrophy of two thumb muscles, sub-acute in its beginning, showing so far as the limited time of observation will permit any inference, no progressive tendency; (*b*) definitely localized dysesthesia. Pain in the right arm had been noticed since her twelfth year. The arm seemed weaker. There was a localized atrophy of the right thumb, with slow reaction to both faradism and galvanism. Cramps in the fingers of the right hand, causing a stiffening of the fingers, had been noticed for five years. Over an area from the internal condyle to pisiform bone there was marked thermo-anesthesia with isolated areas of analgesia, anesthesia and hyperesthesia. In no other parts of the body was either motor disturbance or dysesthesia found. There was no increase of reflexes. The preservation of tactile sensibility in this case makes a diagnosis of syringo-myelia difficult, an invasion of the posterior columns by the gliosis or cavity formation being a late, not an early symptom. This case comes under the class of univadicular palsies, and the root involved is the first dorsal, in such a way as to exclude the sympathetic fibers for the pupil. The absence of any increase of reflexes, so frequent in syringo-myelia, may indicate that the cord is intact. In these cases there is no knowledge on the part of the patient of sensory disturbance, whereas in peripheral neuritis subjective sensory phenomena are the rule. Buzzard thinks this absence of subjective sensation of numbness, or tingling, may prove a differential diagnostic point between root and peripheral neuritis. He quotes an experiment on the macacas of cutting a single spinal root which produced a disturbance of skin sensation to some extent dissociative. Over a limited skin area, much smaller than the total skin field of the root, an abolition of heat sensitivity occurred, without abolition but with some concomitant impairment of actual sensitivity. In the skin of the macacus the pain field and heat field of a single sensory nerve root, are less extensive than is the "touch field" of the same root. This case of the writer corresponds to this description and makes the site of the lesion the junction of the eighth cervical and first dorsal to form the outer cord of the brachial plexus, but attacking a single nerve only, viz.: the first dorsal. The lesion must be beyond the posterior root ganglion as evidenced by the absence of hespat.

NOYES (New York).

THROMBOSIS OF THE MIDCEREBRAL ARTERY, CAUSING APHASIA AND HEMIPLEGIA, WITH REMARKS ON CEREBRAL SKIAGRAPHY. C. W. Burr and G. E. Pfahler (Amer. Jour. of Med. Sciences, Feb., 1904).

The case is of interest chiefly because of the advance in cerebral skiagraphy as showing the possibilities in the differential diagnosis between organic brain lesions causing hemiplegia and those due to uremia. The patient, a woman, age 47 years, had a right hemiplegia, with aphasia. Her only utterance was, "No, no, no. No, no." She was not completely word-deaf, although there was apparently some impairment. She died of uremia, and a necropsy was made the same day. There was extensive destruction in the region of the distribution of the midcerebral artery. The lower halves of the ascending frontal and ascending parietal convolutions were completely destroyed—the upper halves somewhat atrophied. Nothing remained of the island of Reil and only a small portion of Broca's convolution. The supramarginal, angular and first temporal convolutions were destroyed. A part of the second temporal was also destroyed. After the necropsy the brain was replaced and two skiagraphs taken, one from each side. The lesion showed on both negatives, but much more plainly on the affected side. It is evident that the Roentgen rays will be of considerable value in the diagnosis of large cerebral lesions such as new growths, softening, hemorrhage and abscess.

C. D. CAMP (Philadelphia)